Hamilton County Government

Joint Medical/Case Management Records Authorization Form

Office Use Only
Date Rcvd:_____ Dept:_____
No. Pages Rcvd:_____ Expiration Date: _____
Processed by: _____
Notes: _____

1) Important Information.

- HIPAA allows Hamilton County Government (HCG) to require the use of its form for record requests. HCG asks that you use this form when making a request for records.
- Section 7 AND Sections 9 OR 10 must be initialed and signed by the person legally allowed to make this request.
- You have the right to ask for a copy of this form if one is not given to you.
- **42 C.F.R. Part 2 prohibits unauthorized use or disclosure of these records.** If HIPAA covered entities and business associates receive records for treatment, payment, and health care operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against you.
- You can refuse to sign this release form, and it will not affect your treatment, payment, enrollment, or eligibility for benefits.
- This authorization expires one (1) year from the date signed in Sections 9 or 10.
- You have the right to take back (revoke) this authorization at any time, but taking it back does not undo actions already taken based on your prior consent. This must be in writing and sent to the CEC chosen in Section 4.
- E-Mails from HCG are encrypted and will be sent from *noreply@securemail.encrypttitan.net.* Be sure to check your Spam folder! Call the CEC if you do not receive your records.
- Additional information about patient/client rights can be found in HCG's Joint Notice of Privacy Practices. You may receive a copy from the HCG website or any County Department Office listed on the back of this form.

2) Patient/Client Information:

Current Full Name: _____ (First / Middle / Last) Date of Birth: _____ (MM/DD/YYYY)

Previous Name(s) (List All): _____ (First / Middle / Last) Last Four Digits of SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ (Include area code) _____ ***Initial if we may leave a message on this phone's voicemail***

Email Address: _____ ☐ Patient/Client is deceased. Date of death: _____ (MM/DD/YYYY)

3) Purpose of Release:

☐ Continuation of Care ☐ Personal Use ☐ Law Enforcement

☐ Court/Legal Proceedings – if selected no other purpose may be selected ☐ Other: _____

4) Records to be released *from* the following. Check all that apply:

☐ Health Department (HCHD) ☐ EMS ☐ Ambulance Billing

☐ Drug Recovery Court ☐ Mental Health Court ☐ Veterans Treatment Court ☐ Alternative Sentencing – Recidivism Reduction Initiative (RRI)

☐ Other Healthcare Provider: _____ (To request medical records from non-HCG providers) Phone Number: _____ (Include area code)

5) Initial or check beside the record(s) you want to be released.

_____ Medical Record* _____ WIC (Women, Infants & Children) _____ Immunization Record Only _____ Itemized Billing Statements

_____ Dental Record _____ Case Management Record _____ Ambulance Run Report _____ Other: _____

_____ Psychotherapy/Substance Use Disorder (SUD) Counseling Notes** - ***If selected no other records above may be requested. A separate form is required for other records to be requested.***

** **Does not include Dental, WIC, or Case Management records; these must be specifically requested.***
*** **SUD records for deceased patient/client require consent from an executor, administrator, or personal representative (T.C.A. § 33-3-105) or by Court Order (T.C.A. § 33-3-105).***

6) Specific dates to be released. Start date: _____ (MM/DD/YYYY) through End date: _____ (MM/DD/YYYY)

7) Highly Confidential Information. Initial each category you allow to be released. Initial only—no checkmarks. If you do not initial it, we will not release it.

_____ Family Planning/Contraceptive Care _____ STI (Sexually Transmitted Infection) _____ HIV/AIDS Testing/Treatment _____ Alcohol/Substance Use Disorder

8) Where to send records: ☐ Patient/Client – same info in Section 2 ☐ Requestor – same info in Section 9 ☐ Attorney – same info in Section 10

By:
☐ Pick up in person
☐ Mail
☐ Fax
☐ E-Mail

☐ **Other - Person/Place:** _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ (Include area code) Fax: _____ (Include area code)
Email Address: _____

Patient/Client Name: _____ **Date of Birth:** _____
First Middle Last MM/DD/YYYY

If you are an individual, complete only Section 9. If you are an attorney, complete only Section 10.

9) Select one of the following, and complete 9.A-C: ☐ **Patient/Client** ☐ **Patient's/Client's Parent** ☐ **DCS** ☐ **Personal Representative of Estate** - Letters of Administration/Testamentary ☐ **Legal Personal Representative** - Power of Attorney ☐ **Legal Guardian/Conservator** - Court Order or Letters of Guardianship/Conservatorship ☐ **Medical Examiner** ☐ **Law Enforcement** – Badge #_____.

A) Requestor's Information. (Patient/Client do not complete 9A. Go to 9B and 9C.) _____ ***Initial if we may leave you a message on your phone's voicemail***

Requester's Full Name: _____ Phone Number: _____
First Middle Last Include area code

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Fax Number: _____
Include area code

B) Provide a clear color copy of one government-issued photo ID (front and back):

State-Issued: ☐ Driver's License/Handgun Permit ☐ Photo ID

Government-Issued: ☐ Military ID ☐ Passport ☐ Form 1-766, EAD (Employment Authorization Document)

☐ US Certificate of Naturalization/Citizenship or Citizenship ID Card ☐ Other: _____

C) Signature.

By signing, I declare under penalty of perjury (28 U.S.C. § 1746) that the information above is true and that I am legally allowed to obtain these records.

Signature: _____ Date: _____
MM/DD/YYYY

Your request is complete. Submit pages 1-3, along with the required documents from above.

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10) Attorney with legal authority. Complete sections A and B below. ***HCG reserves the right to reject documents that fail to establish an attorney's authority to obtain PHI to include highly confidential information, such as Part 2 records.***

A) Select and provide the required documentation. I am

☐ **Personal Representative of Estate** – Letters of Administration/Testamentary

☐ **Legal Personal Representative** – Power of Attorney

☐ **Guardian/Conservator** – Court Order or Letters of Guardianship/Conservatorship

☐ **Attorney for the duly appointed Personal Representative** – Letters of Administration/Testamentary

☐ **Attorney for Patient/Client/Representative** – HIPAA authorization signed by patient/client and a government ID with signature

Docket No. _____, in the matter of _____ v. _____ In (select one):

☐ Circuit Court ☐ Chancery Court for _____ County, TN ☐ Other Court: _____

B) The Attorney's Signature is Required. Pursuant to 28 U.S. Code § 1746, I hereby declare under penalty of perjury that, as indicated above, I am the authorized representative of the patient/client/legal representative and have legal authority to obtain these records. I attest that my client's signature on any submitted form is valid.

Attorney's Printed Name: _____ Office Phone: _____
Include area code

Mailing Address: _____ Email: _____

Attorney's Signature: _____ BPR No. _____ Date: _____
MM/DD/YYYY

Notice to Attorneys: If you plan to submit a Court Order, whether in lieu of, or in addition to this form, you may contact the HIPAA Privacy Officer who can assist you in assessing whether your order comports with both HIPAA and *Tenn. Code Ann.* § 8-27-910. **Please Note: Court Orders that do not comply with both federal and State law may be subject to legal pleading, as determined appropriate by the Hamilton County Attorney's Office.**

Your request is complete. Submit pages 1-3, along with the required documents from above.

Patient/Client Name: _____ **Date of Birth:** _____
First Middle Last MM/DD/YYYY

Where to Submit your Joint Medical/Case Management Records Authorization form or to take back your consent (Notice of Revocation)

Send your completed 3-page form and required documents to the department you selected in Section 4. The Privacy Officer's contact information is also listed below.

Hamilton County Emergency Medical Services (EMS)
3916 Volunteer Drive
Chattanooga, TN 37416-3817
Email: EMSMedicalRecords@HamiltonTN.gov
Phone: 423-209-6900 / Fax: 423-209-6902

Hamilton County Drug Recovery Court
8395 Hickory Valley Road
Chattanooga, TN 37416
Phone: 423-209-7570

Hamilton County Ambulance Billing
455 North Highland Park Avenue
Chattanooga, TN 37404-2016
Email: AmbulanceBilling@HamiltonTN.gov
Phone: 423-209-6363 / Fax: 423-209-6399

Hamilton County Mental Health Court
401 West MLK Blvd, Suite 3035
Chattanooga, TN 37402-1632
Phone: 423-209-6195

Hamilton County Health Department
921 East Third Street
Chattanooga, TN 37403-2102
Email: HDMedicalRecords@HamiltonTN.gov
Phone: 423-209-8209 / Fax: 423-209-8210

Hamilton County Veterans Treatment Court
401 West MLK Blvd, Suite 3035
Chattanooga, TN 37402-1632
Phone: 423-209-6195

Hamilton County HIPAA Privacy Officer
Hamilton County Attorney's Office
625 Georgia Avenue, Room 204
Chattanooga, TN 37402-1956
Email: HIPAA@HamiltonTN.gov
Phone: 423-209-5989 or 1-833-484-8671

Hamilton County Alternative Sentencing - Recidivism Reduction Initiative (RRI)
6215 Dayton Blvd
Hixson, TN 37343-2710
Phone: 423-209-8600 / Fax: 423-847-4829

HAMILTON COUNTY GOVERNMENT OFFICE USE ONLY.

(A) _____ **Completed in my presence.**
Initials

(B) _____ **Identity verified by [method]:** _____
Initials

(C) _____ **I processed and completed this request for medical records.**
Initials

Employee Signature: _____ Date: _____
MM/DD/YYYY

Interpreter Signature: _____ Date: _____
MM/DD/YYYY